Helpdesk Research Report: Approaches to better target audiences

Date: 22.02.12

Query: Please identify approaches used in marketing (both commercial and also social) and across the wider behavioural sciences to understand, segment and better target audiences beyond the usual social, economic and demographic categories typically used? Where possible, identify the theories of behavioural change which inform these approaches.

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1. Overview

Audience segmentation can be defined as a "data-based method of identifying smaller target groups of people who share some relevant characteristics" (Parvanta et al, 2010: 150). Audience segmentation has its origins in multiple disciplines including the behavioural sciences but is most commonly used for commercial and social marketing. Commercial and social marketing differ in that commercial marketing’s primary purpose is to achieve ‘profit/shareholder value’ and social marketing’s primary purpose is to achieve a social good (e.g. improving health, reducing inequalities) (Blair-Stevens, expert comments). However, they both use forms of audience segmentation to reach their target audience.

Though audiences are often segmented by ‘profile variables’ (i.e. demographic, socio-economic and geographic variables), they can also be broken down by ‘behavioural variables’ (e.g. the frequency of usage, readiness to purchase/use the good), and ‘psychographic variables’ (e.g. lifestyle characteristics, activities, interests and opinions, attitudes and personality). There are also psychosocial variables (e.g. self-esteem, depression, and stress levels), which are conceptually different to psychographic variables, and tend to be used in health research rather than marketing.
The effectiveness of audience segmentation depends on the ability to identify population subgroups that are homogeneous with respect to certain variables associated with a given outcome or behaviour. The greater the degree of homogeneity of an identified subgroup, in relation to a given outcome or behaviour, the more likely a targeted intervention will be effective. Rather than define subgroups, or segments solely by one type of variable, research suggests that combining variable types produce more homogenous segments. For example, Boslaugh et al. (2005) compared the results of audience segmentation that is based on either demographic, health status or psychosocial variables alone, or a combination of all three types of variables. Using psychosocial variables alone resulted in greater variability in segments than health status or demographic variables. Relying on demographic variables alone provided little improvement. However, combining all three produced a significant improvement in homogeneity of the segment.

There are a large number of approaches to target audiences, especially in relation to behavioural change with varying underlying theories of behavioural change. This report provides an overview of these variables and the theories and approaches of behavioural change which employ them.

2. Segmentation Variables

Profile Variables

These are demographic, socio-economic and geographic variables such as age, gender, family size, income, occupation, religion, and education. Another type of variable similar to demographic variables are ‘firmographic’ variables. Firmographic variables relate to organisations in the same way as demographics relate to people (Henning 2008). Commonly-used firmographics include employee size, revenue size, industry, number of locations and location of headquarters.

Behavioural Variables

Individuals can be differentiated according to their behaviours: extent of individuals’ research to understand the benefits sought of a product/offering, the frequency of usage, when the product/offering is decided on or used, the readiness to purchase and attitude towards the product/offering. Other examples include the degree or duration of relevant behaviour, the context and location of behaviour, the public / private nature of behaviour, the degree of social acceptability / stigma, extent of actual (or potential) benefits, attitude to behaviour (problem & desired), the extent of related service / product usage, the attitude & readiness towards change in relation to problem & desired behaviour, and the ability to achieve & the access issues.

Psychographic Variables

Psychographic variables are attributes relating to personality, values, attitudes, interests, and lifestyles (Senise 2007, Marketsegmentation 2008). Rather than focusing on factors such as
age, sex and marital status, psychographic variables relate to a broader picture of consumers’ lifestyles based on their activities, interests and opinions. Psychographic attributes generally involve subjective preferences as opposed to external classifications.

Examples include attitudes and readiness to adopt a product/behaviour; degree of positivity towards product/behaviour; the degree of resistance; personality profile / type; values (personal & community); beliefs and perceptions, knowledge and understanding; self-efficacy and self esteem.

Sharp (2006) states that psychographic variables should not be seen as a replacement for demographic/socio-economic measures, rather an enhancement. However, they are much harder to measure and, in order to be effective, will require understanding of behavioural theory and in-depth research to gain consumer/user insights.

**Psychosocial Variables**

Psychosocial variables relate to ‘influence of social factors on an individual's mind or behaviour, and to the interrelation of behavioural and social factors’ (Martikainen et al. 2002). Psychosocial variables do not seem to be commonly used in commercial or social marketing. Instead psychosocial variables are used in particular as a health research approaches. Examples include self-esteem, depression, stress levels, social support, personality traits, coping styles, and locus of control.

*Figure 1. A tentative schematic representation of psychosocial pathways (Martikainen et al., 2002)*

In figure 1, macro-level structures relate to ownership and control of land and businesses, legal and welfare structures, as well as distribution of income and other resources between groups and individuals. The psychosocial concept would be at the meso-level, along with social formations – religious institutions, the family, the firm, and clubs. The micro-level refers to individual psychological factors. Macro- and meso-level social processes lead to perceptions and psychological changes which in turn can influence health through direct psychobiological processes or through modified behaviours and lifestyles.

**3. Theories of behavioural change**
There are a large number of theories and approaches towards behavioural change derived from disciplines such as psychology, sociology, communication, and political science. These can focus on the enabling environment level, the community level, the interpersonal level, or the individual level. In many cases theorists have contributed towards multiple approaches and the approaches are not mutually exclusive of each other.

Rather than identify a dominant conceptual framework, Glanz, Rimer, and Lewis (2002) argue that one should accept that no single theory or conceptual framework is dominant and instead choose from the multitude of theories. Each approach and theory can provide insights and help think about possible courses of action to promote behaviour change (C-Change, 2010).

Blair-Stevens (expert comments) states that there remains a “lack of appreciation of the richness and diversity of behavioural theory that can inform and assist effective policy and programme development”. For example, in their technical brief, CommGAP (2009) identify the main theories of social behaviour as: Social Cognitive Theory; the Theory of Planned behaviour and the Stages of Change/Transtheoretical model. Blair-Stevens notes that while these theories can have their value in specific contexts, their commonly unquestioned use, particularly of the Theory of Planned behaviour and the Stages of Change/Transtheoretical model, is highly problematic. Instead, Blair-Stevens advocates an ‘open theory approach’, where an “appreciation of the diversity of behavioural theory is incorporated into the way an issue is assessed from the beginning”. This ‘open theory approach’ aims to “include the range of different disciplines that can contribute to understanding of a behavioural challenge and intervention options selection, and the hugely diverse range of theories that every discipline can bring to understanding”.

C-Change (2010) have developed their tools for Social and Behaviour Change Communication based on a wide range of theories and approaches to behaviour change which they have identified. The approaches are summarised as follows:

**Enabling Environment Level**

**Media Theories**

The mass media can focus attention on issues, helping to generate public awareness and momentum for change. Research on *agenda setting* has shown that the amount of media coverage of any given issue correlates strongly with public perception about its importance. The media tell people what to think about. *Agenda dynamics* refers to the relation among *media agenda* (what is covered), *public agenda* (what people think about), and *policy agenda* (regulatory or legislative actions on issues) (Dearing and Rogers 1996). *Media advocacy* refers to civic actions to shape media attention on a specific issue (Wallack 1993). It’s how groups that promote social change persuade the media, through various techniques, to cover their issues.

*Framing* is how issues are presented in news coverage (Goffman 1974; Iyengar 1991). The same issue can be described in different ways depending on the narratives and sources used. Experimental research shows that news frames strongly influence how people perceive issues and think about possible courses of action. *Persuasion* is a form of communication that seeks to influence attitudes or behaviours without the use of force or coercion (Perloff 2003).
Key questions:
- How can the mass media influence public opinion?
- How can the media contribute to changes in the enabling environment?
- Would increased media coverage of the issue help to change perception about its importance among policy-makers and the public?
- How would increased media coverage affect policy discussion?
- How can media coverage of a given issue be expanded and changed?
- Does it make a difference how the media frames the issue?
- How should media decision-makers (e.g. reporters, editors, publishers) be engaged to promote changes?

Social Movement Theories

Social movements refer to collective actions by citizens to promote social changes in policies, laws, social norms, and values (Tilly 2004). Social movements promote legislative and policy changes to advance their causes and build coalitions with allied policy makers. They try to find sympathetic legislators to discuss issues and raise awareness, and seek to influence the legislative process through mobilization, and financial and voting support for allies. To promote change, social movements resort to a combination of different forms of action:

1) **Campaigns**: long-standing activities to demand that authorities specific changes.
2) **Movement Repertoire**: combinations of political action such as coalition building, media statements, rallies, demonstrations, online mobilization, and pamphleteering.
3) **WUNC displays**: participants aim to demonstrate Worthiness, Unity, Numbers, and Commitment. For example, newer social movements in Africa, Asia, and Latin America include faith-based communities, neighbourhood and squatter associations, women’s and human rights groups, peasant cooperatives, and environmental activists.

Key questions:
- How do social movements contribute to changing the enabling environment around a specific issue?
- How does a social movement change policy/legislation around the issue?
- What policy changes might help overall change?
- Is there a social movement supporting change related to the issue?
- What actions has it used?
- What have been its achievements?
- In case of the absence of a movement, how can a movement be developed and sustained?
- What promotes people's participation around the issue?
- What collective actions are needed to change the environment?
- What collective action strategies have been successful to express demands and advance change?

Social Network and Social Support Theory

A web of social relationships that surround and influence individuals characterizes this theory (McKee et al. 2000; Glanz, Rimer, and Viswanath 2008). The structural characteristics of networks refer to several aspects: the degree of homogeneity among members, resource
exchange, emotional closeness, formal roles, knowledge, and interaction among members, and power and influence among members. The functions of social networks refer to social trust, influence, support and criticism, emotional bonds, and aid and assistance. The types of social support can be emotional, informational, instrumental, and self-assessment.

Key questions:
- How do social networks influence individuals’ KAP around the issue?
- How might social networks support possible changes?
- How can social networks be influenced?
- What dimensions (knowledge, attitudes, perceptions) of behaviour/social change can be promoted through social networks?

Social Capital

Social capital refers to the institutions, norms, and values of social networks and their impact on social relationships and institutional resources (Putnam 2000). The theory argues that groups and societies with higher levels of social cohesion and trust are fundamental for societies.

Links tie people with other people with similar interests as well as provide bridges with other groups. Social capital means the social resources that people have and can tap into to engage in various activities, economic, social, cultural, and political.

Key questions:
- What institutions are adequate platforms to promote changes?
- How might trust among people promote changes?
- Where do people gather to discuss common interests? Who do people trust?
- Who do they rely on to develop links and engage in different activities?

Ecological Models

Ecological systems theory suggests that individual behaviours are not only or mainly influenced by psychological factors. They are interdependent with the social context. The social context refers to anything beyond individuals such as social norms, interpersonal relations, culture, and laws and regulations. Consequently individual-level interventions should always take other influencing factors into consideration. Programmes need to understand how changes at the level of neighbourhood, community, institution, and social/political structure might affect individual changes.

The suggested recommendation is to take a multiple-level approach that promotes the same change by tackling various forces of change. For example, an intervention promoting bed net use could include an information campaign stressing benefits supplemented by efforts to improve access to low-cost bed nets and improve local production and supply chains or request government subsidies to provide wider access to the nets.

Key questions:
- What factors in the social context influence individual behaviours? Which ones can be positively affected?
What elements/components of the social ecology are more likely to influence individuals?
What evidence shows successful changes of various factors and their impact on individual behaviours and decisions?
Must change of the social context always have an impact on individual behaviours?

Theories of Complexity

Complexity theorists argue that individuals are part of complex systems characterized by many “interacting agents” (e.g. Waldrop 1992; Lewin 2000; Morin 2008). Human behaviour is non-linear and unpredictable because of the number and diversity of agents and variables in the system and, therefore, there are no foolproof “recipes” for change.

Interventions and activities designed from a complexity standpoint would include all of the diverse actors that might be involved with a given issue. For example, an infection control intervention in a hospital should not be limited to infection control staff but rather should include representatives of all the hospital units that can contribute, including housekeeping, nursing, security, and orderlies.

Key questions:
- What system components affect individual behaviour around the specific issue?
- What system elements can be influenced?
- What is the “most likely point of entry” into the system?
- How are systems organized and how do they avoid chaos and disorganization?

Theories of Change

A theory of change is a “concrete statement of plausible, testable pathways of change that can both guide actions and explain their impact” (Kubisch et al. 2002; Kubisch et al. 2004). A theory of change is often made visible with a “logic model,” a visual representation that charts (or “maps”) a path from the problem to be addressed, to the inputs (available resources), then outputs (activities and participation) to finally arrive at outcomes (short, medium, and long-term results) that ideally will lead to impact (long-lasting change). A theory of change brings underlying assumptions to the surface so that the reasoning behind an intervention can be assessed and adjusted, if necessary.

Note that a sound theory of change needs to be based on a theory of how change actually happens. From this perspective, one should identify the most likely change and drivers of change in a given system. Programmers need to assess possible tipping points of change, their likely impact in the overall system and the feasibility that they can be affected by a program. It is also important to identify emergent change (which is already occurring, whether it’s planned or unplanned), transformative change (critical points that caused major transformations in a given community), and projectable change (the kind of change that can be planned and implemented).

Key questions:
- What are suitable pathways of actions to promote change?
• What changes are already occurring in a community regarding specific issues?
• What likely changes may have positive and negative ripple effects?
• What “secular trends”/emergent changes encourage or discourage proposed changes?
• What changes have already occurred in a given community that offer insights into local processes of change?

Behavioural Economics

*Rational choice* assumes that people are driven to maximize perceived individual benefits. Yet the way choices are structured have proven to affect people’s decisions. If people are offered choice in the form of opt out (e.g., routine HIV testing that patients have to actively “say no” to), more people may make certain choices of advantage, e.g., for public health. Such choices raise questions about whether individuals make decisions independently from the environment. They also suggest that people make certain choices because they are interested in maximizing time, costs, or other factors when making a selection. People can be primed (led, stimulated) to make certain choices just by the structure of options. The easier the choice, the more likely it will be chosen.

*Choice architecture* is the act of nudging people toward more healthful or socially beneficial behaviour by designing available choices in such a way that individuals will be steered toward the “right” choice (e.g., placing vegetables or salad at the beginning of a school lunch display and reducing the availability of competing foods that are fattening; displaying condoms in easily accessible places in kiosks and stores). (See e.g. Kahnemann 2003; Thaler and Sunstein 2008.)

Key questions:
• How can environments be affected to facilitate desirable behaviours?
• What behaviours can be made easier if certain environmental factors are altered (e.g., laws, regulations, presentation, distribution, offerings)?
• Are there examples of successful choice architecture in a given community? What lessons can be considered for the design of other choices around desirable changes?
• Are choices based on rational thought, self control, or selfishness? Or are choices based on rules of thumb, irrationally seeking satisfaction, or spur of the moment decisions?
• Is a policy change needed instead of behavioural appeals?
• What incentives and regulations can be put in place and/or promoted to make certain behaviours beneficial or mandatory?

*Community Level*

*Community Organization*

Community organization emphasizes social action processes through which communities gain control and decision-making over their lives (Glanz, Rimer, and Su 2005). Community organization involves *empowerment, self-determination, and capacity to perform critical tasks.*
Empowerment refers to the process by which individuals and communities gain confidence and skills to make decisions over their lives. Self-determination refers to the capacity of an individual and of communities to make decisions without interference or influence from other actors. Capacity to perform critical tasks refers to the ability to execute actions required to improve conditions.

Key questions:
- What community organizations exist?
- How are communities organized?
- How is power structured around specific issues?
- What organizations can be mobilized towards positive change? What organizations may be opposed to change?
- What local beliefs and practices are or might be linked to change?
- What has been the role of local organizations in local processes of change?

Integrated Model of Communication for Social Change

The Integrated Model of Communication for Social Change describes how social change can happen through a process of community dialogue leading to collective action that affects the welfare of communities as a whole as well as their individual members (Reardon 2003).

The model describes a dynamic, iterative process that starts with a catalyst/stimulus that can be external or internal to the community. This catalyst leads to dialogue within the community that when effective, leads to collective action and the resolution of a common problem.

Key questions:
- Where do people talk about common problems?
- How can dialogue about specific issues be promoted?
- What are the barriers to dialogue around specific issues? How can they be addressed?
- Are there past examples of how local dialogue affects attitudes, opinions, collective action, and/or decisions? What are the lessons that are valuable for future plans?

Theory of Social Norms

The theory of social norms is based on the rules that a group uses to discriminate between appropriate and inappropriate values, beliefs, attitudes, and behaviours – the do’s and don’ts of society (Appelbaum 1970; Jones 1994). Social norms may be explicit or implicit. Failure to conform to norms can result in social sanctions and/or social exclusion. Collective norms operate at the level of the social system (social network, community, entire society) and represent a collective code of conduct. Collective norms are not measured by aggregating individual beliefs (Lapinski and Rimal 2005). Perceived norms are the result of individuals interpreting and perceiving values, norms, and attitudes that others around them hold. Perceived norms are further distinguished into injunctive norms (what ought to be done; similar to subjective norms of the Health Belief Model) and descriptive norms (what is actually done by other individuals in the group, what the perceived prevalence is of the behaviour in question) (Lapinski and Rimal 2005).
Stigmatization is a frequent method through which groups establish negative norms. Instead, social norms are reinforced through routine group approval. Social norms vary and evolve through time and among generations and between social classes and social groups (e.g., acceptable dress, speech, and behaviours). What prevalent social norms encourage or discourage proposed changes?

Key questions:
- What alternative norms may be emphasized to promote desired changes (e.g., tobacco cessation can be promoted through appealing to social norms about health, economic savings, consideration for the health of relatives, and so on)?
- Are there gaps between collective norms and perceived norms (the difference between what individuals perceive to be dominant norms and actual norms)?
- Are proposed changes stigmatized? If so, what beliefs underlie stigma? What social norms can be promoted to counter stigma (e.g., real men take care of women)?
- Do people have positive or negative views about proposed changes? What are the bases for such beliefs (e.g., religion, culture, economic incentive, policy)?
- What do people believe should be the dominant (subjective) norms around a proposed change/issue?
- Have there been recent social norm changes in a given community? If so, what are the explanations? Has generational change anything to do with it? What other insights can be drawn from that experience?

Social Convention Theory

Social conventions are at work when an individual follows a social rule, because of 1) expectations that many others follow the social rule, 2) preference to do the same as others, and 3) compliance being in his/her interest. Influencing social conventions requires effort at the community level because even if an individual or small family unit changes its practices, the social convention will still be in place (Mackie and LeJeune 2008).

For example: In the case of female genital cutting (FGC), families may be reluctant to abandon the practice if they think that as a result their daughter will be less marriageable. If the entire community abandons the practice all the daughters will be on a level playing field. For social conventions to change, a critical mass of community members needs to agree to the change. The tipping point for change occurs when a critical mass of community members adopt the change and make a public commitment.

In Senegal, the TOSTAN project has had success with basic human rights education for women that has resulted in community-organized and public declarations of the commitment of the entire community to abandon the practice of FGC.

Key questions:
- What social conventions need to be changed? Why do specific conventions persist?
- What social networks can be mobilized to promote new conventions?
- What social conventions have recently changed in the community? Why? Is there wide public knowledge about those changes?
- What factors support social convention?
- Why do people do it? What would happen if people changed conventions?
• What might discourage people from practicing the current convention?

Theory of Gender and Power

*Gender inequality* is a social construction that results from long-term processes of socialization and education (Connell 1987). *Distribution of work* according to gender norms as well as *unequal pay* produces economic inequalities for women. *Power inequalities* are reflected and perpetuated in conditions that, for example, put women at increased risk for disease (such as HIV/AIDS) because of an inability to negotiate correct and regular use of condoms, and more vulnerability to illness/death in instances where they have no access to transport to health facilities.

Gender approaches aim to meet the different needs of men and women in ways that contribute to power balance and equitable practices. They also seek to find ways to empower women through the acquisition of skills, information, services, and technologies. Depending on the level of desired change, gender approaches in programming can be *neutral, gender sensitive, transformative, and empowering* (Gupta 2000).

Key questions:
- What gender inequalities exist around the specific issues? Who makes decisions?
- How are those decisions linked to broad gender power divisions?
- What factors maintain gender inequalities around specific issues? What factors discourage women from gaining more power?
- How can gender equitable decision-making be promoted? What social norms can be tapped to strengthen women’s power?
- Are there other areas in a given community where men and women have more equitable relationships? If so, why?
- Are there men who don’t act like “most men” around specific issue? If so, why?

Culture-Centred Approach

The culture-centred approach involves designing change interventions and activities that are “consistent with a people's and community's cultural frameworks” (Airhihenbuwa 1999: 7), i.e., *culturally relevant*. Local cultural systems are the basis for the development of meanings (or interpretations) about specific social change issues. This approach recognizes the value of *local/community expertise* and knowledge and views community members as agents capable of promoting change within their own communities. (See Airhihenbuwa 1999; Dutta-Bergman 2007).

A culture-centred approach involves inquiry into the preferred modes of communication within a given community—oral, written, mixed, visual, traditional, mediated modes of communication.

A culture-centred approach views local culture as a resource rather than a barrier to change. When ethical challenges arise, such as domestic violence or the solicitation of sex by older men (“sugar daddies”) from young girls, local culture and religious/moral norms can be evoked as a *shaming technique* (see Ttofi and Farrington 2008) to appeal *emotionally* to perpetrators to cease their behaviour.
Key questions:
- How do communities think about a given issue in terms of their own culture?
- How does local culture affect people’s beliefs and practices about the issue?
- How do people talk/communicate about the specific issue? What are the preferred modes of communication?
- Do people have opportunities to talk about a given issue? If so, where and when? Are there obstacles?
- What local/traditional values might promote “good” practices and changes?

The Positive Deviance Approach

The Positive Deviance Approach seeks to understand why a minority in a given community practices healthy behaviours and to integrate those insights into effective planning (Zeitlan, et al. 1990; Pascale and Sternin 2005). For example, in a community where most children are malnourished, positive deviance would try to analyze why some children are well nourished—those who deviate from the norm in a positive way. Reasons could be access to economic resources, social capital, religious beliefs, past experiences, and so on.

A basic premise of this asset-based approach is that change is community-based and community-driven – that is, communities have local expertise, solutions, and resources (e.g., alternative norms, agents) to promote change.

The basic steps of the Positive Deviance Approach are (4 Ds):
- **Step 1.** Define the problem and desired outcome.
- **Step 2.** Determine common practices.
- **Step 3.** Discover uncommon but successful behaviours and strategies through inquiry and observation.
- **Step 4.** Design an initiative based on the inquiry findings.

The results of a positive deviance initiative never yield a recipe for change since each community has a different challenge, context, and local expertise. Thus, identifying community capacity to promote desirable changes is critical. Capacity refers to agents (who drive change), resources (how), setting (where), and target (who is the subject of change) (McLeroy et al. 2003).

Key questions:
- Are there people who do not conform to the negative norm? Why do they act in that way? Are there common elements among them?
- Is it possible to spread their “unique/deviant” norms across the community? Are there barriers? How can they be addressed? What will it entail to mainstream deviant positive behaviours?
- What resources do communities have to promote desirable changes? How can they be mobilized towards positive change?
- Who (individuals/groups) may be more inclined or disinclined to promote change? What are the reasons? Will informing about examples of positive deviance persuade people who practice undesirable behaviours?
Theory of Organizational Change

Understanding how to create change in organizations is a critical aspect of health and development promotion. Organizational theories can provide insight into how to manage the adoption of organizational policies or institutionalization of a particular intervention within an organization or help explain how an organization may actually discourage certain behaviours with its structure of programs and services (Glanz, Rimer, and Lewis 2002).

It is important to understand what drives an organization to change, what demands and leads change, and how change is implemented. The interest of organizations in stability, hierarchy, and predictability may discourage change. The need for renewal, survival, and consolidation may encourage change.

Key questions:
- What organizations are responsible or exercise influence over specific issues (e.g., quality of health services)?
- What organizational practices and rules affect a given issue (e.g., service provision quality and hours)?
- What organizational policies and dynamics negatively affect a given issue?
- How is change possible in a specific organization? Is there a previous example of change? If so, how did it happen? Was it gradual or sudden? What parts of the organization are more likely to be changed?
- What may motivate organization members to support change? Who has power over change?
- How can changes be institutionalized in the organization?

Diffusion of Innovations

Diffusion of Innovations is a process by which an innovation is spread in a given population over time (Rogers 2003). Under the right conditions, innovations (new services, products, best practices) can be successfully introduced/communicated and adapted at the individual, community, and organizational level. For diffusion of innovation to be successful it must have a relative advantage (be better than the existing one); be compatible with existing values (perceived social acceptability); be easy to implement, not too complex; be possible to try (triability); and have observable benefits.

Not everyone in a given community is similarly predisposed vis-à-vis specific changes—people have different attitudes, beliefs, and experiences that affect their disposition to change. When opinion leaders in the community support the innovation, they communicate their approval and thus increase the likelihood and pace of adoption. Individuals often improve, adapt, or re-invent an innovation to fit their needs/context. Innovations are more likely to be incorporated if they fit into pre-existing needs.

Key questions:
- What attitudes exist toward specific innovations?
- Who (individuals, groups) is more likely to adapt the innovation? Who is less likely? Why?
• What are the advantages of the given innovation over current practices/uses?
• What opinion leaders strongly support innovations and might be mobilized to provide public support?
• Have people already experienced the innovation?
• If so, what happened? Do people have easy access to try the innovation?
• What might be the benefits of adopting the innovation for different groups of people?

Social Marketing Approach

“Social marketing is the application of commercial marketing technologies to the analysis, planning, execution and evaluation of programs designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare and that of their society” (Andreasen 1995). (See also McKenzie-Mohr 2011).

*Product/practice* is what is being promoted. *Price/cost* is the ease of access and barriers to using the product or practice. Perceived cost may not be identical to actual cost (people may have wrong impression about how easy or difficult is to access the product). *Places/access points* refer to where people might have access to the product—where the product is distributed and made available. *Promotion* refers to the information/activities platform to let people know about products and their characteristics. *Community-based social marketing* (CBSM) relies on formative research conducted in the community to ensure that existing and perceived benefits and barriers are understood prior to the design of an intervention/campaign/activity. CBSM involves the promotion of both actions and/or products.

Key questions:
• What are the benefits of a given product?
• Why would people try, use, and continue to use a new product?
• What is the cost/price for people to access the product?
• How can the product be effectively distributed in the population? Where will people access it?
• How can the product be promoted? What appeals, format, and content will attract people’s attention and reach them most effectively?

Models of Patient-Centred Communication Functions

*Paternalistic physician-patient* relationships with professional distance or *consumerist* (patient as consumer = client) approaches to physician-patient relationships make a big difference for the patient. The *paternalistic* idea of a hierarchical relationship is still the norm in big parts of the world. In comparison, a patient-centred relationships encourage clients to see themselves as consumers of health care, while providers are trained to expect a more assertive and responsible patient. (See Reeder 1972; Holman and Lorig 2000; Glanz, Rimer, and Lewis 2008.)

*Health literacy* is an individual’s capacity to obtain, process, and communicate information about health and is needed for patient *self-management* (e.g., health information seeking, coping with treatment effects, disease monitoring, navigating referrals, etc.).
Social distance is the number and importance of dissimilarities between providers and clients. It may be based on perceptions or objective indicators that do not necessarily have to match.

The concept of patient preferences speaks to the fact that patients have varying expectations for their own role and that of the provider, often associated with socio-demographic and cultural characteristics.

Key questions:
- What difference does it make to call patients clients?
- What advantage is there for physicians to have more assertive patients?
- How can physicians encourage patient self-management?
- What difference would social distance make to the client-provider relationship? And what difference does a good client-provider relationship make for health outcomes (e.g., adherence to HIV treatment)?
- What decisions should be made by the provider and what decisions can a client make?

**Interpersonal Level**

**Social Learning Theory/Social Cognitive Theory**

These theories describe the dynamic interaction of the person, behaviour, and the environment in which the behaviour is performed. Five key factors can affect the likelihood that a person changes a health behaviour: 1) Knowledge of health risks and benefits, 2) Self-efficacy (confidence in one’s ability to take action and overcome barriers), 3) outcome expectations (the cost and benefits of adopting a behaviour), 4) goals people set (and strategies for realizing them), 5) perceived social and structural facilitators and/or impediments/barriers to the desired change. (See eg. Bandura 1977, 1997, 2001, 2004; Glanz, Rimer, and Su 2005)

The concept of reinforcement suggests that responses to a behaviour decrease or increase the likelihood of reoccurrence.

In addition, the theory suggests that people learn not only from their own experiences but by observing others performing actions and the benefits they gain through those actions. This concept of modelling has been influential in developing entertainment education programs.

Key questions:
- How do people come to know about a given issue?
- How do people feel about their ability to practice certain actions? Is self-efficacy high or low?
- Who influences people’s knowledge, attitudes, and behaviours?
- What barriers discourage practicing certain behaviours?
- How can specific practices be reinforced/reminded/maintained?
- Who are credible role models who perform the targeted behaviour?
- How can collective efficacy about specific issues be promoted?

**Diffusion of Innovations through Opinion Leaders**
Since they are recognized as opinion leaders in a given issue, specific members of a community may lead by example. Their opinions and behaviours may encourage people to try new behaviours and continue to maintain practices. Imitation of “positive” behaviour may be the result of people following opinion leaders whom they admire and trust around specific issues. Opinion leaders in one area (e.g., breastfeeding, sanitation practices) are not necessarily influential around other issues.

Key questions:
- Who are opinion leaders on specific issues in a community or group?
- Why are they trusted and followed?
- Have they introduced new behaviors? If so, what happened?

**Theories of Dialogue**

Dialogue can be more than “conversation”—it can be conceived of as a respectful orientation towards others and as a way of *raising consciousness* about social realities (including inequality in power and economic relations). A “dialogic” approach of raising awareness through interpersonal contact is the opposite of a one-way education whereby an expert transmits information to an empty/ignorant receiver/audience (banking model). (See e.g. Freire 1993; Walton 1998.) Dialogue communication aims to achieve empathy and a *connection* that invites reflection and potential action.

Key questions:
- What might a dialogic communication strategy look like?
- What should the role of the expert be in communication for social and behaviour change?
- What activities and processes can facilitate consciousness-raising and connection?

**Individual Level**

**Hierarchy of Effects Model**

Considers the effects of communication and is based in the practice of advertising (Chaffee and Roser 1986). Together, these variables are referred to as KAB (*knowledge, attitude, and behaviour*) by many researchers or in relation to product purchase as: Awareness, Knowledge, Liking, Preference, Conviction and Purchase. The aim would be for individuals to move up the hierarchy from knowledge about a product/public good/action towards behaviour.

Key questions:
- What knowledge and attitudes might lead to desirable behaviours?
- How do we know that specific behaviours might be changed if specific knowledge and attitudes are changed?

**Theory of Self-determination**
Motivation to change behaviours happens along a continuum from being controlled by others (external motivation) to being able to self-determine (internal motivation). Internal motivation leads not only to more enjoyment of a behaviour change but also to more persistence to maintain a new behaviour (Osboldiston and Sheldon 2002).

Key questions:
- Do people feel that they or others control decisions about specific behaviours?
- Do people believe they can change or promote changes? What is the basis for those beliefs?
- Do people hold fatalistic beliefs about change? Or do they think that change is possible?
- Have people effectively promoted and achieved positive change? If so, which ones?

**Theory of human motivation**

Humans must first meet basic physiological and safety needs (food, water, shelter, etc.) before addressing higher needs such as social relations, esteem, or self-actualization (e.g., a fulfilling career) according to Maslow's hierarchy of needs (Maslow 1943). In relation to behaviour change, this hierarchy provides some reference to understand the barriers to change for any behaviour.

The theory suggests that we need to consider whether people have basic needs met when planning and designing an intervention. Success may be limited in circumstances/contexts where people are focused on meeting basic needs or have other priorities.

Key questions:
- What are people’s perceived priority needs? What are their most urgent needs around specific issues (e.g., health, education)?
- Do people perceive that the promoted change is important?
- Is it possible to present the promoted change in terms of existing perceived priorities?

**Stages of Change/ Transtheoretical Model**

This model focuses on stages of individual motivation and readiness to change behaviours. (See Proschaska and DiClemente 1988; Glanz, Rimer, and Su 2005; Glanz, Rimer, and Viswanath 2008.)

1. **Pre-contemplation**: individual has no intention of taking action within the next six months.
2. **Contemplation**: individual intends to take action in the next six months.
3. **Preparation**: individual intends to take action within the next 30 days and has taken some behavioural steps in this direction.
4. **Action**: individual has changed behaviour for less than six months.
5. **Maintenance**: individual has changed behaviour for more than six months.

Key questions:
What are the different stages across several groups in a community vis-à-vis proposed changes/issues?
Are there any obvious explanations to understand such differences across groups?
Why do they hold different attitudes or are in different stages?
How can stage transition be promoted?
What appeals can be mobilized to promote stage change?
What motivates people to act to maintain behaviour change? Can those factors be tapped into to promote changes among peoples in other, previous stages?

Theory of Planned Behaviour

This theory posits that *behavioural intention* is the most important determinant of behaviour (Ajzen 1985). Behaviours are more likely to be influenced when: individuals have positive *attitudes* about the behaviour; the behaviour is viewed positively by key people who influence the individual (*subjective norm*), and the individual has a sense that he/she can control the behaviour (*perceived behavioural control*).

Key questions:
- Do individuals want to perform the behaviour? How likely are individuals to perform behaviour?
- Are individuals opposed to the behaviour?
- Why do some individuals have positive or negative intentions?
- Do people feel they can control behaviours?
- What might motivate people to have positive attitudes?

Health Belief Model

This model highlights individuals’ perceptions of their vulnerability (*perceived susceptibility*) to a health condition, 2) the *perceived severity* of the health condition, 3) the *perceived benefits* of reducing or avoiding risk, 4) the *perceived barriers* (or costs) associated with the condition, 5) *cues to action* that activate a “*readiness to change*,” and 6) confidence in ability to take action (*self-efficacy*). (See Rosenstock 1975; Glanz, Rimer, and Su 2005; King 1999)

Thus in the case of HIV prevention, for example: An individual must:
- Believe they are at risk for HIV/AIDS.
- Believe that HIV/AIDS is serious and deadly.
- Believe that avoiding HIV/AIDS is both worthwhile and possible.
- Feel and be able to take preventative measures.

Key questions:
- What populations are at risk? What is their level of risk?
- How can risk perceptions be changed or maintained?
- Why do people believe that they at risk? Why do some people believe they are not at risk?
- How do risk perceptions match objective risk (the statistical probability of being at risk)?
- What perceive barriers and perceived benefits for practicing specific behaviours exist?
- What actions can be promoted to reduce risk and risk perception?
• Are there groups who seem ready to change/practice new behaviours?
• Do people feel they are capable of changing behaviours?
• Do people understand how change is possible – what needs to happen?

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6. Additional information

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About Helpdesk research reports: Helpdesk reports are based on 2 days of desk-based research. They are designed to provide a brief overview of the key issues; and a summary of some of the best literature available. Experts are contacted during the course of the research, and those able to provide input within the short time-frame are acknowledged.